Massachusetts Division of Health Care Finance and Policy

Uncompensated Care Pool:

Frequently Asked Questions (FAQs)

Regulations, Eligibility, and Billing

January 2006

Stephen McCabe, Acting Commissioner

CONTACT INFORMATION

For providers:

MBR Questions:
Contact 888-665-9993, the central number of the MassHealth Enrollment Centers.

Virtual Gateway Application Questions:
Contact the Virtual Gateway Help Desk at: 800-421-0938.

UCP Help Line:
Contact the Division of Health Care Finance and Policy Help Line: 877-910-2100.

For Patients:

UCP Help Line: 877-910-2100.

To File a Grievance Against the UCP:

To file a grievance, the patient should send a letter to:

Division of Health Care Finance and Policy
Attn: UCP Grievance
Two Boylston Street
Boston, MA 02116

The letter should include, at a minimum, the patient's **name and address**. If possible, it should also include information about the situation, the reason for the grievance, the **provider's name** (if a provider is involved), etc. The more information that the patient gives, the better. It is very important to include the provider's name if a provider is involved.

Questions about filing a grievance should be directed to the UCP help line at:
877-910-2100.

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1. APPLICATION QUESTIONS

NEW

1.1 Application Overview

1.1.1 Application Process:

Pursuant to 114.6 CMR 12.00, patients may no longer apply directly for Low Income Patient (UCP) status; they must first apply for MassHealth through the MassHealth application process. Individuals who are ineligible for MassHealth are screened for Low Income Patient status, and, if so determined, are notified by MassHealth. Patients who are Low Income Patients can be found in the REVS system.

There are some exceptions to this requirement. Hospitals and community health centers must continue to submit applications to DHCFP for Low Income Patients using the existing electronic desktop Free Care software application for the following groups:

- Minors seeking confidential services,
- Family members of deceased applicants,
- Individuals applying for Medical Hardship.

1.1.2 MBR Requirement:

The MBR can be used as an application for both UCP and MassHealth. Using the MBR will allow patient data to be processed through the MA-21 system that links to REVS. This will allow an applicant's determination to be state-wide and viewable on REVS upon determination. An MBR must be used if the patient refuses to sign the Permission to Share Information (PSI) form.

1.1.3 Applications at Home:

Providers can hand out or send a paper MBR to the patient and instruct the patient to return the completed form directly to the MassHealth CPU. Alternately, providers may direct applicants to return the application to the provider and the provider may then send the application to the CPU. The provider should not, however, use the application to fill out an application via the Virtual Gateway using the information on the form.

1.1.4 Applications with No Social Security Number (SSN):

Individuals may still apply for MassHealth even without an SSN. These individuals may still be eligible for certain MassHealth programs, and/or be determined Low Income Patients. These patients will appear in REVS.

1.1.5 Age 65 and Older Population:

Virtual Gateway applications and paper S-MBRs now determine both MassHealth and UCP eligibility for the Community Elder population. By using this application, a patient aged 65 or older may receive a MassHealth or UCP determination.

Once providers are trained to use the new Virtual Gateway application for seniors, Electronic Free Care applications may no longer be used for this population. Electronic Free Care Applications may only be used for confidential applications, and for Medical Hardship applications.

1.1.6 Asset Test for Applications Over 65

UCP determinations do not require an asset test (with the exception of Medical Hardship applications). However, to apply for the UCP, all patients must first apply for MassHealth. The application for patients aged 65 and older requires an asset test to determine eligibility. The information provided in the asset portion of the MassHealth application is used to determine MassHealth eligibility but does not factor into the UCP determination.

1.1.7 Confidential UCP Applications:

For minors that require confidentiality, Low Income Patient status can continue to be determined using the FC desktop application. Providers must collect documentation of the patient's request for confidentiality and keep this documentation (such as a signed affidavit or letter from the patient) in the patient's file with the UCP application.

If a minor requests confidential services and is already known to the MassHealth system (e.g. the family includes MassHealth members, or the family had MassHealth eligibility within the last year), MassHealth has processes for ensuring that the patient can receive confidential services without the family being notified. The MassHealth Enrollment Center should be contacted; a separate FC application is not necessary.

In the case of minors who are covered by a private insurance policy but require confidential services, it should be noted that, in these cases, using the MassHealth system does not ensure complete confidentiality. These patients should continue to use the electronic FC application to ensure that claims are processed confidentially.

Providers who have transitioned onto the Virtual Gateway can continue to use the electronic FC application tool for this population to ensure that confidential services can be provided.

1.1.8 Deceased Persons:

If possible, a MassHealth application process should be submitted within 10 days (for the under 65 population) or 90-days (for the over 65 population) from the date of death. Medical expenses leading up to the death are billable to MassHealth if the applications are completed within this period. An additional DDU Supplement form may need to be completed for individuals who

were not otherwise categorically eligible – death is considered a disability for the purpose of this application.

If an application has not been submitted within the 10/90 day deadline, an electronic Free Care application may still be submitted for the deceased individual.

1.2 Required Income and Residency Documentation and Verifications

1.2.1 Residency Requirement & Verification:

Low Income Patients must be Massachusetts residents, but, in accordance with the MassHealth application process, residency will be established through letters to applicants sent by MA-21. If a letter is returned for an inaccurate address, it will be assumed the applicant is a non-resident and MA-21 will terminate the applicant's Low Income Patient status.

1.2.2 Homelessness & Residency Verification Process:

The MBR and Virtual Gateway common intake forms include an indicator for homelessness that enables complete processing of the application and prevents homeless MassHealth members or Low Income Patients from being terminated due to a lack of residence.

1.3 Affidavits, Virtual Gateway Processes, and Partial Deductible Calculation

1.3.1 Pending Virtual Gateway Applications:

If a patient has a VG application submitted, but no determination has been made and this patient presents for services at another facility, this patient's status is "pending." S/he should not submit another application. The provider can contact the original provider where the application was completed to inquire about its status. The provider can also contact the MEC at 888-665-9993 to check on the status of an application.

1.3.2 MassHealth Income Affidavits:

Low Income Patient determinations through MA-21 will be completed according to the MassHealth rules of necessary documentation.

For applicants with income, MassHealth documentation is required for all eligibility determinations. For income documentation, MassHealth considers affidavits "reliable evidence" only as a last resort when no other documentation is available. If an applicant claims no income, then under MassHealth rules, no documentation is required, and the application will be processed as it is currently for MassHealth applicants with no income.

1.3.3 Seasonal Workers & MassHealth Income Calculations:

For these applicants, a filed US tax return is the best form of documentation because it shows annual income. If a seasonal worker provides pay stubs, the income calculated will be higher than the worker's actual income. A letter from the employer is also valid and is considered appropriate documentation of variable income.

1.3.4 Deductible Calculation for Partial UCP:

The Partial UCP deductible is calculated as follows:

[Gross family income – (200% FPL)] x 40% = annual deductible

Example: for a family of 2 at 300% FPL (using the MassHealth income guidelines)

$37, 476- ($24,984) x 40%= $4,996.80

2. ELIGIBILITY QUESTIONS

NEW

MassHealth Re-Determinations and Notices

When a MassHealth or UCP patient receives a re-determination that results in no coverage change, and there has not been a gap in coverage, the eligibility begin date for that patient does not change.

For example, if a patient with full UCP, determined on December 15, 2004, completes his/her eligibility review form and receives a re-determination for continued full UCP eligibility, the notice will show the benefit effective date as December 15, 2004, not December 15, 2005. This is because there was no coverage gap or change in eligibility. If this patient's re-determination results in a change to MassHealth Standard coverage, a new benefit effective date will apply.

Premium Assistance – Family Assistance:

The UCP may be billed for all wrap-around services including co-pays, deductibles, and non-covered UCP eligible services for individuals on Premium Assistance – Family Assistance. Some individuals may also have MassHealth Standard in which case the pool may not be billed for co-pays.

Ex. A family with children is income eligible for Premium Assistance, but above 150% FPL. As a result the family will receive Premium Assistance because the children are eligible. However, the adults receive insurance coverage only because their children are eligible for Premium Assistance of Employer Sponsered Insurance (ESI). The UCP may be billed for any private co-pays and deductibles for the income eligible adults, but may not be billed for any MassHealth Standard co-pays or deductibles that the children may incur.

Premium Assistance – Buy In:

If an individual receives Premium Assistance through Buy In but is not income eligible for any other MassHealth program, the Pool may be billed for any remaining co-pays and deductibles charged by the private insurance or Medicare as well as any non-covered UCP eligible services.

NOTE: *Some 65+ with Premium Assistance may not show up in REVS as they have been determined through the PACES system. MassHealth operations is working to correct this problem. In the interim, a PACES determination will be accepted as documentation of Low Income Patient status.*

Voluntarily Leaving CMSP, Insurance, and the UCP:

The CMSP statute and regulations require that children be uninsured to be eligible for CMSP. However, some families are being enrolled in the CMSP even though they have other insurance.

Families who are otherwise insured who wish to terminate their CMSP coverage may do so without affecting their UCP status. MA-21 will issue a closing reason for these individuals which will reflect that the child / children have other insurance.

2.1 UCP Eligibility Determination: The Basics

2.1.1 Overview of Low Income Patient Determination:

Pursuant to 114.6 CMR 12.00, patients may no longer apply directly for Low Income Patient (UCP) status; they must first apply for MassHealth through the MassHealth application process. Individuals who are ineligible for MassHealth are screened for Low Income Patient status, and, if so determined, are notified by MassHealth. Patients who are Low Income Patients can be found in the REVS system.

There are some exceptions to this requirement. Hospitals and community health centers must continue to submit applications to DHCFP for Low Income Patients using the existing electronic desktop Free Care software application for the following groups:

- Minors seeking confidential services,
- Family members of deceased applicants,
- Individuals applying for Medical Hardship.

2.1.2 Length of Eligibility Period:

Low Income Patient status is maintained for a period of one year, beginning on the start date as determined by MassHealth (i.e., 10 days prior to the date the MassHealth application is received). In addition, a provider may bill the UCP and receive payment for services rendered up to 6 months before the date of determination. These Low Income Patients must comply with the MassHealth re-determination process and requirements.

2.1.3 Portability and Proof of UCP Status:

If a patient's Low Income Patient status is determined through the Virtual Gateway or the paper MBR, it is portable – that is, it is applicable at all acute care hospitals and community health centers in Massachusetts that participate in the UCP. Any provider can go into REVS and check patient status.

2.2 UCP Wrap-around and Temporary Status

2.2.1 CommonHealth Members and Low Income Patient status:

All patients who qualify for MassHealth are Low Income Patients. Therefore, providers may bill the UCP for patients enrolled in CommonHealth for Eligible Services provided to said patients that are not covered by CommonHealth.

2.2.2 Resident Students and UCP Wrap-around:

Every full-time and part-time student enrolled in a certificate, diploma or degree-granting program of higher education must participate in a qualifying student health insurance program or in a health benefit plan with comparable coverage as defined in 114.6 CMR 3.04

Patients may apply to be determined Low Income Patients, and providers may bill the UCP for services not covered by MassHealth, other insurance or benefits.

2.2.3 Age 65 and Over & UCP Wrap-around (QMB, SLMB, QI-1):

Individuals with eligibility in the MassHealth Buy-In categories, including Senior Buy-In (QMB), Buy-In for Specified Low Income Medicare Beneficiaries (SLMB), and Buy-In for Qualifying Individuals (QI-1), have Medicare and also have family incomes of less than 135% FPL. Therefore, they are also eligible for UCP 'wrap' for services not covered by MassHealth or Medicare.

The UCP will always be the payer of last resort and will only pay for services not covered by either program.

2.2.4 Disability Determination Pending Period & Low Income Patient Status:

Individuals who have completed a DDU (Disability Determination Unit) supplement and require a disability determination will be considered Low Income Patients during this "pending period" if they are income eligible. Once a determination has been made, the applicant will convert to another MassHealth category on REVS if the applicant's disability affords them MassHealth coverage.

2.3 Benefit Programs and the UCP (EAEDC, CenterCare, Healthy Start, CMSP, etc.)

EAEDC:

EAEDC provides coverage for emergency physician services at a hospital, all services provided at a CHC, and certain other services. Those medically necessary services not covered by MassHealth for this population may be billed to the UCP. Providers must make every reasonable effort to have EAEDC patients enroll in MassHealth and document all such efforts. Most

EAEDC patients are eligible for MassHealth Basic and may enroll in MassHealth without submitting an MBR / Virtual Gateway common intake application. These patients should be instructed to call the Health Benefits Advisor at 800-841-2900 to enroll. If an EAEDC patient has an EAEDC card, but does not appear in the REVS system, a new MA-21/VG application will need to be completed for that individual for them to be eligible to receive healthcare benefits. EAEDC patients should only be instructed to call and choose a PCC if they appear in REVS.

Premium Assistance – Family Assistance:

The UCP may be billed for all wrap-around services including co-pays, deductibles, and non-covered UCP eligible services for individuals on Premium Assistance – Family Assistance. Some individuals may also have MassHealth Standard in which case the pool may not be billed for co-pays.

Ex. A family with children is income eligible for Premium Assistance, but above 150% FPL. As a result the family will receive Premium Assistance because the children are eligible. However, the adults receive insurance coverage only because their children are eligible for Premium Assistance of Employer Sponsered Insurance (ESI). The UCP may be billed for any private co-pays and deductibles for the income eligible adults, but may not be billed for any MassHealth Standard co-pays or deductibles that the children may incur.

Premium Assistance – Buy In:

If an individual receives Premium Assistance through Buy In but is not income eligible for any other MassHealth program, the Pool will wrap any remaining co-pays and deductibles charged by the private insurance.

NOTE: *Some 65+ with Premium Assistance may not show up in REVS as they have been determined through the PACES system. MassHealth operations is working to correct this problem. In the interim, a PACES determination will be accepted as documentation of Low Income Patient status.*

Healthy Start:

Providers must check REVS to determine patient status. Individuals approved for Healthy Start after July 1, 2004 will be listed on REVS under the coverage type: LMTD HLTHY STRT. Eligible women approved for Healthy Start before July 1, 2004 will not have their Healthy Start eligibility listed in REVS. If REVS shows LMTD HLTHY STRT, providers may bill the UCP for Eligible Services provided that they are not covered by either MassHealth Limited or MassHealth Healthy Start.

CenterCare:

CenterCare enrollees use a CHC as their primary care provider. Since CenterCare is not a MassHealth program they will not be listed on REVS. To determine eligibility, the provider must complete the MassHealth application process with the patient.

Other Non-MassHealth Eligibility and UCP Wrap-around:

Low Income Patient status is not implied by a patient's eligibility in other, non-MassHealth programs. REVS contains patient eligibility information about several other programs besides MassHealth, such as Senior Care Options, DMH programs, and pharmacy programs. For example, a patient in the REVS system with the restrictive message of "Mental Health Services Only" is in REVS due to eligibility in a DMH (Department of Mental Health) program and does not have MassHealth eligibility and does not imply that the UCP can be billed for services not covered by other insurance or programs.

To determine eligibility for MassHealth / Low Income Patient status, the patient would have to complete an MBR or Virtual Gateway application.

CMSP:

Providers must check REVS to determine patient status. Individuals approved for CMSP after July 1, 2004 will be listed in REVS under one of two coverage types: CMSP Only, or LMTD CMSP. Providers may bill the UCP for services not covered by any other insurance or program for individuals with MassHealth Limited and CMSP who are also Low Income Patients.

The CMSP REVS message may be used as a proxy for income. Those individuals who have CMSP with Limited are below 200% FPL and receive Full Low Income Patient status. Persons appearing as CMSP Only without a restrictive message are Partial Low Income Patients.

If a patient is known to be a partial Low Income Patient, and the exact income of the family can be determined, the provider must calculate the deductible using the formula found at 114.6 CMR 12.03 as shown at Sec. 1.7.4 of this document. Otherwise, providers may calculate a deductible for partial Low Income Patients as though their income was equal to 201% FPL.

UCP Wrap-around Deductibles for CMSP patients between 201 - 400% FPL:

Since REVS does not display the income of CMSP patients, and the REVS message is only useful in determining ranges of income, patients whose income is determined to be between 201-400% FPL will all be assessed a deductible amount as if they had an income level equal to 201% FPL. Those CMSP patients seeking services at a CHC will be assessed a sliding scale fee as though their income were equal to 201% FPL. Providers should always check all members of the family in REVS to see if a family deductible amount is present. If a family deductible can be ascertained using REVS, it should be used. Providers may also ask if the patient has their MassHealth determination letter which will reflect their deductible amount. The specific deductible amounts for 2005 are reflected below. CMSP REVS messages may be used as a proxy for income as follows:

CMSP and Limited: <200% FPL
CMSP Only: 200-400% FPL
CMSP Only w/Restrictive Msg.: 400< % FPL

Family Size	201%	Deductible
1	$19,236	$38.28
2	$25,788	$51.32
3	$32,341	$64.36
4	$38,894	$77.40
5	$45,446	$90.44
6	$51,999	$103.48
7	$58,551	$116.52
8	$65,104	$129.56

Voluntarily Leaving CMSP, Insurance, and the UCP:

The CMSP statute and regulations require that children be uninsured to be eligible for CMSP. However, some families are being enrolled in the CMSP even though they have other insurance.

Families who are otherwise insured who wish to terminate their CMSP coverage may do so without affecting their UCP status. MA-21 will issue a closing reason for these individuals which will reflect that the child / children have other insurance.

Currently, individuals who are terminated from CMSP for non-payment of premiums will be closed out, and, if income eligible, will be determined Low Income Patients.

2.4 UCP Eligibility Re-determination

2.4.1 New Income Documentation, Partial UCP Deductible:

Whenever a patient reports a change in circumstances, such as a change in family size or income, a re-determination can be completed using the MassHealth application process. New determinations, including new Partial UCP deductible amounts are possible. If the patient has bills being applied to a deductible from a previous determination, they can be applied toward the new deductible.

2.4.2 MassHealth Re-Determinations and Notices:

When a MassHealth or UCP patient receives a re-determination that results in no coverage change, and there has not been a gap in coverage, the eligibility begin date for that patient does not change.

For example, if a patient with full UCP, determined on December 15, 2004, completes his/her eligibility review form and receives a re-determination for continued full UCP eligibility, the notice will show the benefit effective date as December 15, 2004, not December 15, 2005. This is because there was no coverage gap or change in eligibility. If this patient's re-determination results in a change to MassHealth Standard coverage, a new benefit effective date will apply.

2.4.3 Re-determination and Eligibility Period:

A re-determination due to a change in financial circumstances or family size does not trigger a new eligibility period. If the new information (new pay stubs, for example) results in no change to the eligibility category, then the eligibility dates remain the same and the patient will not receive a MassHealth notice. If the MassHealth / UCP status is upgraded, downgraded, or terminated, then the patient receives a MassHealth notice and the "benefit effective date" changes. However, this does not mean that the patient receives a "new" one-year eligibility period. The timing of the annual review does not change because the "review date" is based on the date of initial application.

Low Income Patients who have had their status determined through the MassHealth process should follow the MassHealth processes and procedures for submitting changes. They are required to contact MassHealth regarding any changes in income, family size, employment, disability status, health insurance, and address within 10 days or as soon as possible.

2.4.4 Termination from UCP:

If a patient does not respond to the annual review process at MassHealth, and is consequently terminated from MassHealth, they cannot be determined a Low Income Patient, nor will they "default" into the UCP. Patients applying for the UCP must first be screened and/or enrolled in MassHealth prior to applying for UCP. If the patient completes the required information, the patient can be appropriately determined for MassHealth and UCP.

Low Income Patients whose eligibility is determined through the MassHealth application process (MBR or Virtual Gateway) are subject to the review procedures of MassHealth. These patients must comply with the review process to retain their Low Income Patient status.

2.4.5 Failure to Pay MassHealth Premiums:

If a patient is processed and determined ineligible for MassHealth because s/he has failed to pay his/her MassHealth premium the patient will be screened for determination as a Low Income Patient. If determined to be a Low Income Patient, REVS will indicate his/her status as a Full UCP or Partial UCP patient.

3. ELIGIBLE SERVICES

NEW

3.1 UCP Eligible Services: The Basics

3.1.1 Overview of Eligible Services:

Providers are allowed to bill the UCP for medically necessary services provided to Low Income Patients as defined in 114.6 CMR 12.03.

A medically necessary service is defined as follows: A service that is reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity.

Medically necessary services shall include inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act. Medically necessary services shall not include: non-medical services, such as social, educational, and vocational services; cosmetic surgery; canceled or missed appointments; telephone conversations and consultations; court testimony; research or the provision of experimental or unproven procedures including, but not limited to, treatment related to sex-reassignment surgery, and pre-surgery hormone therapy; and the provision of whole blood; except the administrative and processing costs associated with the provision of blood and its derivatives.

3.2 Critical Access Services Provision—Billing, Eligibility, etc.

3.2.1 Critical Access Services:

Critical Access Services are defined in the regulations at 114.6 CMR 12.03(2)(b).

Time of Day Clarification
Time of day is not a factor in the determination of critical access services. If urgent care, as defined in the regulation, is needed, it may be provided at a hospital.

Can providers bill a Patient who would like to continue to see their current doctor at a hospital instead of receiving primary care at a CHC?
Providers may not bill Low Income Patients except for MassHealth and UCP co-pays and deductibles.

3.2.2 Psychiatric Treatment (Outpatient):

Psychiatric treatment by a specialist is a Critical Access Service.

3.2.3 Ancillary Services on a Hospital Campus (Radiology, Laboratory):

These are Eligible Services and therefore may be billed to the UCP.

3.3 Specific Services

3.3.1 Family Planning or Contraceptive Services:

Family planning services are only eligible UCP services if they are medically necessary, Eligible Services according to the UCP regulations. The following services would be considered medically necessary Eligible Services by the UCP.

- Contraceptives may be considered medically necessary if pregnancy would exacerbate an existing medical condition. Contraceptives may also be covered if they are needed to treat a medically necessary condition (i.e. some contraceptives have secondary uses which may be unrelated to pregnancy prevention, but may help treat another medically necessary condition).
- Abortions may be considered medically necessary if carrying the pregnancy to term would endanger the life or health of the mother.
- Fertility services may not be billed to the UCP.

All providers are subject to audit and should keep documentation in each patient's file to demonstrate medical need.

Family planning services for low-income men, women, and children may be available in your community. Providers or patients can contact the Massachusetts Department of Public Health Family Planning Program at 617-624-6060 or toll-free at 877-414-4447 for more information.

3.3.2 Home Health Services (VNA) Services:

Home Health / VNA services **are not** Eligible Services per regulation 114.6 CMR 12.00, which specifically excludes home health services; therefore VNA services may not be billed to the UCP.

3.4 Medical Hardship

3.4.1 Eligible Medical Expenses:

The regulation stipulates that eligible medical bills for Medical Hardships are Allowable Medical Expenses. These expenses are not limited to Eligible Services, and may include bills for physician visits, tests, surgeries, etc. that are not necessarily eligible for UCP reimbursement.

3.5 Other

3.5.1 MassHealth Members with No Dental Coverage:

Providers may bill the UCP for medically necessary dental services provided to MassHealth members if those services are not covered by MassHealth.

3.5.2 UCP Billable Services for MassHealth Members:

Services not covered by MassHealth, but that are UCP "eligible services," may be billed to the UCP. MassHealth co-pays and deductibles are not considered eligible services and may not be billed to the UCP.

3.5.3 MassHealth PCCs and Billing the Pool for other Non-Covered Services:

Providers may not submit claims to the UCP for MassHealth members who receive services at a PCC that is not their designated PCC.

4. REVS QUESTIONS

NEW

4.1 Basics

4.1.1 REVS Checks:

Low Income Patient status can be checked using REVS. REVS will always show the richest aid category for an individual. If a patient is eligible for MassHealth then a MassHealth message will be visible; if the patient is not eligible for MassHealth but is determined to be a Low Income Patient, then a UCP message will be visible. The provider may bill the pool for medically necessary Eligible Services rendered to MassHealth patient that are not covered by any other insurance or benefit.

4.1.2 Statewide Determinations, REVS and UCP:

Low Income Patient and MassHealth determinations are accessible through REVS and participating providers throughout the state are able to verify patient status through REVS.

REVS will always show the richest aid category for an individual. If a patient is eligible for MassHealth then a MassHealth message will be visible; if the patient is not eligible for MassHealth but is determined to be a Low Income Patient, then a UCP message will be visible. Once a patient is determined eligible for MassHealth, providers can bill the Pool services not covered by MassHealth, other insurance, or another program without any additional determinations or applications.

UCP determinations through the "old" Free Care application – i.e. for deceased persons, Medical Hardship, or confidential applications – will continue to be facility-specific. These UCP determinations will not be accessible through REVS.

4.1.3 REVS and UCP Wrap-Around:

To receive payment for services not covered by MassHealth, the division recommends that the provider keep a REVS print-out documenting MassHealth eligibility.

4.1.4 "ZZ" numbers in REVS:

The ZZ number is a member ID that is generated when an individual does not have a social security number (SSN).

If a patient does not have an SSN, then a REVS check using name and DOB will result in a response that does not include a field for SSN. The response will include the field "Member ID" for the ZZ number.

4.1.5 Permission to Share Information (PSI) Forms and Notification of Status:

Before a patient can submit an application through the Virtual Gateway (VG), he/she must sign a permission to share information (PSI) form that allows the provider to process the application. Both the patient and the provider named on the PSI form will receive letters from MassHealth notifying them of the outcome of the determination. If the applicant uses the paper MBR, the provider will only get a letter if the patient fills out a PSI and requests that a letter be sent to the provider. PSIs are required for the Virtual Gateway common intake application. PSIs are not required for paper MBRs, but patients have the option to fill them out.

4.2 Different Determinations between Providers and REVS

4.2.1 Different UCP Determinations in REVS (Ex. Full UCP for one date of service, Partial UCP for another):

Providers should use the most recent determination shown on REVs to determine the patient's status. If a patient goes from Partial UCP to Full UCP, the provider may bill the UCP for any unpaid bills for eligible services up to the deductible amount.

4.2.2 Different UCP Determinations on Different Dates:

Providers should use the most recent determination shown on REVS to determine the patient's status. If a patient goes from Partial UCP to Full UCP, the provider may bill the UCP for any incurred unpaid deductible amount.

5. BILLING QUESTIONS

NEW

5.1 Documentation Requirements (General)

5.1.1 UCP Determination, Documenting:

If the patient has applied for UCP through the MassHealth application process and appears on REVS, the provider can keep a REVS print out documenting MassHealth/Low Income Patient status on the date of service in question.

5.1.2 Partial UCP Deductible, Documenting Fulfillment of:

Without proof that an individual has met his/her Partial UCP deductible, claims for services cannot be written off to the Uncompensated Care Pool. Providers are responsible for tracking bills if a patient has no other family members and uses only one facility. Patients are responsible for tracking their own bills if more than one member of the family is using UCP services, or if patients are using more than one medical facility to receive their care. REVS will not be updated to reflect the current amount owed toward the deductible, nor will it reflect when the deductible is met.

5.2 MassHealth / DMH Related

5.2.1 Services Not Covered by MassHealth & UCP Billing:

When a patient is enrolled in MassHealth, providers can bill the UCP for Eligible Services that are not covered by MassHealth without any additional determinations or applications.

Payment by the UCP for services rendered to patients not covered by MassHealth, other insurance, or programs is as follows:

- MassHealth co-pays may not be billed to the UCP
- MassHealth deductibles may not be billed to the UCP
- Services not covered by MassHealth, but that are Medically Necessary services, may be billed to the UCP.

5.2.2 DDU Pending Period & Billing UCP:

For allowable UCP claims during a Disability Determination Unit (DDU) pending period, providers have two options: Claims for Eligible Services may be written off to the UCP and later voided if MassHealth approves the disability. Alternatively, the provider may wait until MassHealth eligibility is determined before billing the claims to MassHealth or the UCP if the patient's disability is denied.

The UCP is always the payer of last resort; if the patient is later found to be eligible for MassHealth, the provider is required to void any claims made to the Pool and bill those claims to MassHealth.

5.2.3 Billing Low Income Patients who have a MassHealth CommonHealth Deductible:

A patient who is determined a Low Income Patient because s/he has yet to meet a CommonHealth deductible can choose to be billed for services that would normally be billed to the UCP to acquire bills toward their deductible. Patients should not be prevented from acquiring bills toward a MassHealth deductible because of their Low Income Patient status.

Such patients with potential CommonHealth eligibility will show up in REVS with Low Income Patient status, but if the patient tells the provider that s/he is trying to meet a CommonHealth deductible, the hospital or CHC is allowed to bill the patient for the MassHealth deductible. Regulation 114.6 CMR 12.08(3) allows providers to bill patients for MassHealth deductibles. The provider should note in the patient's file that the patient has asked to be billed for the purposes of meeting a MassHealth deductible.

5.2.4 MassHealth PCCs and Billing the Pool for other Non-Covered Services:

Providers may not submit claims to the UCP for MassHealth members who receive services at a PCC that is not their designated PCC.

5.2.5 REVS Message "Mental Health Services only; not Eligible for MassHealth." Billing UCP for Non-Mental Health Services:

Low Income Patient status is not implied by a patient's eligibility in these programs. REVS contains patient eligibility information about several other programs besides MassHealth, such as Senior Care Options, DMH programs, and pharmacy programs. This patient is in the REVS system due to eligibility in a DMH (Department of Mental Health) program and does not have MassHealth eligibility.

To determine eligibility for MassHealth / Low Income Patient status, the provider would have to do a separate MassHealth application through the Virtual Gateway or using the paper MBR.

5.3 UCP Deductible

5.3.1 Proof of Meeting Partial UCP Deductible:

Without proof that an individual has met his/her Partial UCP deductible, claims for services cannot be written off to the Uncompensated Care Pool. Providers are responsible for tracking bills if a patient has no other family members and uses only one facility. Patients are responsible for tracking their own bills if more than one member of the family is using UCP services, or if patients are using more than one medical facility to receive their care.

5.3.2 Prior Medical Bills & Meeting UCP Deductible:

Patients can apply prior paid medical bills to their UCP deductible if those services meet the criteria of Eligible Services, and were provided to the patient (evidenced by date of service) during the period during which they are determined to be Low Income Patients. The eligibility period for patients determined to be Low Income Patients is from 6 months prior to the date of determination through one year after the date of determination.

Bills incurred before the eligibility period are not eligible for use against the Partial UCP deductible.

5.3.3 Partial UCP Deductible and Community Health Centers:

When a Partial UCP patient receives services at a Community Health Center (CHC), the CHC uses the patient's income information to calculate, on a sliding fee scale basis, the percentage of the fee for which the patient is responsible. Once that percentage has been established, the patient is responsible for that percentage of the fee every time s/he receives CHC services until such time as s/he meets the deductible amount. The CHC may bill the remainder of the CHC fee to the UCP.

5.3.4 MassHealth Spend-downs and Partial UCP Deductibles:

If a patient must meet both a MassHealth spend down/deductible and an UCP deductible the patient may use the same expenses towards meeting both deductibles -- as long as the expenses used to count towards the UCP deductible were for medically necessary services as defined under 114.6 CMR 12.00. If the MassHealth deductible was never met, then the Partial UCP deductible applies and must be fulfilled.

NOTE: A Low Income Patient CAN use these bills to meet the Medical Hardship contribution.

5.4 Retroactive Billing Period

5.4.1 Billing Period:

The current regulation allows providers to bill to the UCP for services rendered up to 6 months prior to the date of application. Services billed to the Pool after the end of the patient's eligibility period (due to billing cycle delays) are allowable as long as the service date falls within the patient's eligibility period.

5.5 Residency Requirements

5.5.1 Residency Requirement and Billing ER Bad Debt:

Providers are required to check REVS prior to writing off ERBD claims to the Pool in order to ensure that the patient does not have MassHealth or UCP. The requirement is designed to prevent ERBD claims that could be covered by another payer.

5.6 Billing Low Income Patients

5.6.1 Billing Low Income Patients for Non-Eligible Services:

Regulations prohibit providers from billing Low Income Patients (114.6 CMR 12.08 (3)) with the exception of co-pays and deductibles required under MassHealth; Partial UCP; UCP Pharmacy Co-pays; Emergency Aid to the Elderly, the Disabled and Children program (EAEDC); the Healthy Start program; the CenterCare program; or CMSP. Non-UCP Eligible Services that are still provided to these patients cannot be billed to patients.

5.6.2 Billing Low Income Patients for Services Provided Before the UCP Eligibility Period:

Regulations prohibit UCP providers from billing Low Income Patients (114.6 CMR 12.08 (3)). Even services provided before the eligibility period – such as services provided before the 6 month retroactivity period – cannot be billed to Low Income Patients.

5.7 Other

5.7.1 Deposits:

The policies on deposits and payment plans have not been changed. Deposits are allowed for Partial UCP and Medical Hardships. Per regulation 144.6 CMR 12.08 (1)(f), deposits for Partial UCP patients must be limited to 20% of the deductible, up to $500; deposits for Medical Hardship patients must be limited to 20% of the medical hardship contribution, up to $1,000.

5.7.2 Billing the UCP for EMTALA Level Screening:

Emergency level screening is medically necessary and is an Eligible Service which may be billed to the UCP provided that the patient has been determined to be a Low Income Patient. If the patient is not determined to be a Low Income Patient, providers must follow the appropriate ERBD collection requirements prior to submitting the claim for screening to the UCP.

5.7.3 Pharmacy at an Affiliated HLHC:

Since the individual writing the prescription at the HLHC is affiliated with the hospital, and operating under the hospital's license, the prescription may be billed to the UCP.

6. CHC Questions

6.1 CHC Pharmacy Questions

6.1.1 340B Pharmacies & Drugs not on the MassHealth Drug List:

If a CHC 340B pharmacy wishes to dispense a drug that that is not on the MassHealth approved drug list, they may do so if that drug has been approved by the CHC's internal P&T committee provided that the drug is not on the MassHealth excluded drug list. This could include drugs that are preferred for documented clinical reasons as well those that can be obtained more inexpensively than a generic equivalent due to 340B pricing.

6.1.2 Dispensing Fees for Medications Provided through a Free Pharmaceuticals Program:

CHC 340B pharmacies may bill the dispensing fee only for prescriptions provided to Low Income Patients to the Pool even if that individual is using a pharmaceutical company sponsored free drug program (e.g., Share the Care) as long as the drug is dispensed through the center's pharmacy. Providers may not bill the Pool for free or donated prescribed drugs where the drugs are stored and handed out from a site other than the pharmacy (e.g., secured closet near exam rooms).

6.1.3 CHC and Pharmacy Co-pays:

CHCs may collect a co-pay to cover reasonable remaining pharmacy costs, but are given the flexibility to create their own co-pay structure pursuant to 114.6 CMR 11.08(3)(a)(3)(b). However, the cumulative revenue from all patient co-pays is not to exceed 10% of the aggregate Actual Acquisition Cost (AAC) of brand drugs dispensed through the pharmacy and un-reimbursed reasonable dispensing costs exceeding the $7.50 dispensing fee.

6.1.4 Partial UCP Patient Contribution for Prescriptions at a CHC:

A Partial-UCP patient may be required to make two separate payments towards the cost of filling a prescription at a CHC, a patient contribution and a pharmacy co-pay. All Partial-UCP patients must contribute a portion of the cost of their prescription based on the appropriate income determinate sliding scale. For example: if a patient is required to contribute 20% of the bill, then the patient may have to pay **20%(90% AAC + $7.50)** for any brand-name prescriptions or **20%(100% AAC + $7.50)** for generic drugs**.** This portion of the patient contribution counts toward their deductible. Some CHCs may also charge a pharmacy co-payment, in addition to the Partial Patient contribution (see 6.1.3 for more information). Patients *are not* required to pay a separate fee for a CHC visit if there was no physician visit.

6.1.5 Pharmacy Co-pays and Partial UCP deductibles:

Pharmacy co-pays cannot be counted towards a partial deductible. However, any additional amount owed by the patient based on the sliding scale cost of the prescription may be counted toward the patient's deductible.

If a CHC assesses pharmacy co-pays pursuant to 114.6 CMR 11.08(3)(a)(3)(b), those pharmacy co-pays do not count towards a patient's partial UCP deductible. However, the patient's sliding scale contribution for the prescription counts toward the patient's partial UCP deductible.

6.1.6 Registering a CHC's 340B Pharmacy status with the UCP:

Before a CHC can bill the UCP for prescribed drugs provided through its pharmacy, the center must email their 340B ID number, and the date upon which the CHC plans to begin billing the UCP. This information should be sent ***no more than*** 3 months before the date billing commences. Please send the registrations to Rosa Alvarado at the Division of Healthcare Finance and Policy at rosa.alvarado@state.ma.us.

6.2 CHC Billing Issues (Unique to CHCs)

6.2.1 CHC Sliding Scale Payments and Inability to Determine FPL:

If a Low Income Patient is determined to be a Partial-UCP patient but their specific income cannot be determined, they are to be assessed a fee on the CHC sliding scale as though their income were 201% FPL.

6.2.2 UCP Payments to CHCs for Prescriptions; Partial & Full UCP patients:

Full
The UCP will pay CHCs 90% of the Actual Acquisition Cost (AAC) of brand drugs and 100% AAC for generic drugs + a $7.50 dispensing fee.

The patient may be required to pay a co-pay set by the CHC as per 114.6 CMR 11.08(3)(a)(3)(b).

Partial
The UCP will pay CHC's the portion of the AAC and $7.50 dispensing fee not covered by the patient's sliding scale CHC contribution. For example if a patient is required to contribute 20% of the bill, the CHC will be reimbursed: **80%(90% AAC Brand + 100% Generic + $7.50**).

If a CHC assesses pharmacy co-pays pursuant to 114.6 CMR 11.08(3)(a)(3)(b) (see above), those pharmacy co-pays do not count towards a patient's partial UCP deductible. However, the patient's sliding scale contribution for the prescription – e.g. 20 %(90% AAC Brand + 100% AAC Generic + 7.50) – counts toward the patient's partial UCP deductible.

See also: **2.8.3**